

WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
CHRISTY ANNE BAUER, R.N.,	:	LS0806053NUR
RESPONDENT.	:	

[Division of Enforcement Case #'s 06 NUR 358 & 06 NUR 442]

The parties to this action for the purposes of Wis. Stat. § 227.53:

Christy Anne Bauer, R.N.
4887 S. 78th Street
Greenfield, WI 53220

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Board of Nursing
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board of Nursing. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Christy Anne Bauer, R.N., Respondent, date of birth August 20, 1970, is licensed by the Wisconsin Board of Nursing as a registered nurse in the State of Wisconsin pursuant to license number 140616, which was first granted April 1, 2002.
2. Respondent's address of record with the Department of Regulation and Licensing is 4887 S. 78th Street, Greenfield, WI 53220.
3. At all times relevant to this matter, Respondent was employed as a registered nurse by Nursing Centers, a temporary staffing agency in West Allis, Wisconsin.
4. Between May 2006 and July 2006, Respondent worked as a registered nurse at St. Francis Hospital (Wheaton Franciscan Healthcare) in Milwaukee, Wisconsin.
5. According to the pharmacy director at St. Francis Hospital, an inventory of several narcotics revealed that Respondent handled and dispensed significantly more of the narcotics than did other nurses. Between June 26, 2006 and July 27, 2006, Respondent dispensed 52.63% of all morphine used in the intensive care unit. The percentage of morphine dispensed by other nurses individually during the same period ranged from 1.05% to 8.42%. The pharmacy director further reported that Respondent had a consistent pattern of wasting unusual quantities of the narcotics.

6. Staff at St. Francis Hospital reviewed records of narcotics removed by Respondent from the automatic drug dispensing unit. Records from a random sample of eight days between May 2006 and July 2006 revealed that during the days examined, Respondent removed a total of 60 mg of Morphine and 10 mg of hydromorphone for which Respondent could not account.

7. On May 10, 2006, Respondent removed morphine for a patient who was not under her care. Respondent never initialed the patient's medication administration record to indicate she had administered the medication.

8. During a July 28, 2006 investigative meeting with St. Francis Hospital staff, Respondent denied taking or wasting the missing narcotics, and said that all drugs were given to patients. However, Respondent had frequently removed narcotics at levels beyond those prescribed.

9. During the July 28, 2006 investigative meeting, Respondent admitted to careless record keeping.

10. During the July 28, 2006 investigative meeting, Respondent further admitted that she gave medication to a comatose patient without a physician's order.

11. In December 2006, Respondent worked as a registered nurse at Synergy Health-St. Joseph's Hospital in West Bend, Wisconsin.

12. On December 5, 2006, pharmacy staff at St. Joseph's Hospital became aware that Respondent had pulled an abnormally large amount of hydromorphone from the automated dispensing unit in a relatively short period of time. Records from the dispensing unit established that Respondent pulled 4 mg of hydromorphone at 4:32 pm and 5:23 pm, 2 mg at 5:46 pm and 4 mg at 6:40 pm, and 2 mg at 8:35 pm. According to the physician's order, the patient for whom the hydromorphone was prescribed was to receive 2 mg per half hour/4 mg per hour. Between 4:32 pm and 5:46 pm, Respondent pulled 10 mg, and therefore pulled more of the drug than had been authorized by the physician's order for that period of time.

13. Respondent did not document administration of any of the hydromorphone in the medical record of the patient for whom it had been prescribed.

14. Respondent told local police that she pulled the hydromorphone in advance of actual administration to save time. Respondent stated that after pulling the hydromorphone, she stored it in a locked drawer on the unit until she administered it to the patient.

15. Respondent denied taking the narcotic for her own use. Respondent claimed she had administered the hydromorphone, as prescribed, to the patient. She acknowledged that she did not document administration of any of the medication and explained that she had been busy and did not have time to document the administration. Respondent said she remained with the patient for fifteen minutes after administering the drug to insure the patient experienced no adverse effects. When confronted, Respondent could not explain why she did not document administration of the hydromorphone during the time she remained in the patient's room. Instead, she said that she was "in and out" during the fifteen minutes.

16. Respondent acknowledged that her acts of prematurely removing the hydromorphone and in failing to document its administration violated the hospital's policies. Respondent admitted that she knew she had made errors in patient care in this regard.

17. Respondent was asked to provide a blood or urine sample to corroborate her claim that she had not ingested the hydromorphone and Respondent refused.

18. In conjunction with the December 5, 2006 investigation, police searched Respondent's car and purse. Inside Respondent's purse, police found a pill crusher with Oxycodone residue. Additionally, police found two short straws known to police as "snorting straws," commonly used for ingesting powdered drugs through one's nose. The snorting straws contained methylphenidate.

19. Further investigation also revealed that another patient received hydromorphone on November 30, 2006 at 8:47 pm. Hospital records indicated the patient received no additional hydromorphone until December 1, 2006, when Respondent reported administering hydromorphone at 4:00 pm, 6:00 pm, and 8:14 pm. However, Respondent removed the hydromorphone from the automated dispensing device at 3:47 pm, 6:36 pm, and 8:12 pm.

20. Oxycodone is a Schedule II controlled substance pursuant to Wis. Stat. § 961.16(2)(a)11.

21. Methylphenidate is a Schedule II controlled substance pursuant to Wis. Stat. § 961.16(5)(d).

22. Hydromorphone is a Schedule II controlled substance pursuant to Wis. Stat. § 961.16(2)(a)8.

23. During the time periods at issue, Respondent did not have prescriptions for oxycodone, methylphenidate or hydromorphone.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and authority to enter into this stipulated resolution pursuant to Wis. Stat. § 227.44(5).

COUNT ONE

2. Respondent, by obtaining and administering a drug other than in the course of legitimate practice and as otherwise prohibited by law, as set out above in paragraphs 5, 6 and 8, has committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT TWO

3. Respondent, by obtaining and administering a drug other than in the course of legitimate practice and as otherwise prohibited by law, as set out above in paragraph 7, has committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT THREE

4. Respondent, by obtaining and administering a drug other than in the course of legitimate practice and as otherwise prohibited by law, as set out above in paragraphs 12-16, has committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT FOUR

5. Respondent, by obtaining and administering a drug other than in the course of legitimate practice and as otherwise prohibited by law, as set out above in paragraphs 18, 20-23, has committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT FIVE

6. Respondent, by obtaining and administering a drug other than in the course of legitimate practice and as otherwise prohibited by law, as set out above in paragraph 19, has committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT SIX

7. Respondent, by engaging in the conduct as set out above in paragraph 10, practiced beyond the scope of practice permitted by law, and has therefore committed misconduct and unprofessional conduct as defined by Wis. Admin. Code § N 7.04(5) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT SEVEN

8. Respondent, by engaging in the conduct as set out in paragraphs 7 and 9, engaged in a practice which violates the minimum standards of the profession of nursing necessary for the health, safety or welfare of a patient, as defined by Wis. Admin. Code § N 7.04(a) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT EIGHT

9. Respondent, by engaging in the conduct as set out in paragraphs 13-16, engaged in a practice which violates the minimum standards of the profession of nursing necessary for the health, safety or welfare of a patient, as defined by Wis. Admin. Code § N 7.04(a) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

COUNT NINE

10. Respondent, by engaging in the conduct as set out in paragraph 19, engaged in a practice which violates the minimum standards of the profession of nursing necessary for the health, safety or welfare of a patient, as defined by Wis. Admin. Code § N 7.04(a) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The license of Christy Anne Bauer, R.N. as a registered nurse in the State of Wisconsin is hereby **REVOKED**.
2. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of \$4,590.00 pursuant to Wis. Stat. § 440.22(2).
3. Payment shall be mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817
4. This Order is effective on the date it is signed.

Wisconsin Board of Nursing

By: Kathleen Sullivan
A Member of the Board

6/5/08
Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	STIPULATION
CHRISTY ANNE BAUER, R.N.,	:	LS _____ NUR
RESPONDENT.	:	

[Division of Enforcement Case #'s 06 NUR 358 & 06 NUR 442]

It is hereby stipulated and agreed, by and between Christy Anne Bauer, R.N., Respondent; and Sandra L. Nowack attorney for the Complainant, Department of Regulation and Licensing, Division of Enforcement, as follows:

1. This Stipulation is entered into as a result of pending investigations of Respondent's licensure by the Division of Enforcement (files 06 NUR 358 & 06 NUR 442). Respondent consents to the resolution of these investigations by stipulation and without the issuance of a formal complaint.

2. Respondent understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses on her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Respondent has been provided an opportunity to obtain advice of legal counsel prior to signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's Order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Administrative Law Judge for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. Attached to this Stipulation are Respondent's current wall and wallet registration certificates. If the Board does not accept this Stipulation, Respondent's certificates shall be returned to the Respondent with a notice of the Board's decision not to accept the Stipulation.

7. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent or her attorney, if any, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

8. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

9. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order would constitute an agency finding within the meaning of Wis. Stats. §§ 48.685 and 50.065. Should Respondent wish

to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to commencement of such employment.

10. The Division of Enforcement joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

Christy Anne Bauer, R.N.
Respondent
4887 S. 78th Street
Greenfield, WI 53220

Date

Sandra L. Nowack
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date